CHRISTENSEN
HEARING ANALYTICS

Name: _____

Please check the items that apply to you.

- ❑ Ringing in my ears
- ❑ Trouble hearing a movie in the theater
- ❑ Itching in my ears
- ❑ Unable to hear words clearly
- ❑ Other people shout
- ❑ Trouble hearing in a crowd
- ❑ Trouble hearing the television
- ❑ Decreased hearing low/high noises
- ❑ Other people tire of repeating words
- ❑ I become frustrated at not hearing

Other problems, explain below:

_____

_____

_____

Symptoms I am concerned about:

_____

_____

_____

How did you learn about Christensen Audiology and Hearing Aid Center?

| | | |
|---|---|---|
| KFOR Radio | KOLN/KGIN TV | Facebook |
| Lincoln Journal Star | Time Warner Cable | Internet |
| KLIN Radio | Google Search | Other _____ |
| Yellow Pages | Webpage | |

This information is only used for Christensen Audiology and Hearing Aid Center purposes.

Thank You

CHRISTENSEN
HEARING ANALYTICS
6140 Village Drive, Suite 1, Lincoln, NE 68516 • 402.489.3450 • Fax 402.489.3452

## Patient Information

Today's Date: _____

**Name:** _____

**Gender:** ❒ Male ❒ Female **Personal Status:** ❒ Single ❒ Married ❒ Other

**Date of Birth:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Home Phone:** _____ **Work:** _____

**Cell Phone:** _____

**Email Address:** _____

❒ Check this box for email updates and other information

**Primary Physician Information: (required for submitting to insurance)**

**Name:**_____**Phone:**_____

May we leave messages regarding your health care information on voicemail/answering machine? Yes No

Are we able to discuss your health care information with another individual? Yes No

If yes, with whom?
Name: _____ Phone Number: _____
Relationship: _____

Name: _____ Phone Number: _____
Relationship: _____

Emergency Contact:

Name: _____ Phone Number: _____

Relationship: _____

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# Financial Policy

Welcome to our office. Please read this information about our financial and billing policies. If you do not have insurance, or are using CareChoice payment option, you need to make arrangements with our billing staff. We accept cash, personal checks, Money Orders, MasterCard, Visa, or Discover Card.

If you have insurance that we are billing for you then we will need a copy of your current insurance card, or insurance company and policy number. You will need to authorize payment directly to us. ***You*** are responsible for paying us for any services not covered by insurance. We will send you a monthly statement so that you know when your insurance company has made a payment and what the remaining balance is.

When there is a balance on your account we will send you a monthly statement, including any new charges.

Unless arrangements have been made with our finance/billing department, accounts not paid in full within 90 days (after trial period) are considered past due. We will contact you regarding the account and attempt to make arrangements with you. If we cannot reach you then we will submit your account to a collection agency.

There will be a charge of $35 for each returned check.

If you have any questions about this information, please call our billing office at 402-489-3450 ask for the Office manager.

If you have any questions about your insurance that we are billing for you please call our office ask for the Insurance Specialist.

***"I certify the accuracy of the billing information and I authorize the release of any medical information necessary to process my medical claims."***

***Patient or Authorized***
***Signature_____Relationship_____Date_____***

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# Acknowledgement of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Christensen Audiology & Hearing Aid Center's Notice of Privacy Practices or have read a copy in the black binder in the office. I have read about the use and disclosure of my health insurance information, and other concerns regarding my health information.

_____ _____

Signature of Patient Date

_____

Signature of Personal Representative (if applicable)